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ABSTRACT

All states have laws mandating that certain individuals report suspected occurrences of child abuse. Mandatory reporting statutes, their administration, and their judicial interpretation have created many ethical, legal, and clinical dilemmas. The abrogation of the confidentiality in the therapeutic relationship is probably the foremost ethical dilemma created by the mandated reporting statutes. There may be specific problems involved when reporting instances of sexual molestation. Reports of physical or sexual abuse which lead to judicial proceedings are less frequent today than in the past, but the potential social injury to the family is still enormous. Few studies have compared the number of reports made with the number of cases of actual physical or sexual abuse in a given jurisdiction. There is no documented causal connection between mandatory reporting and a decrease in the amount of child abuse itself. In spite of the resulting ethical and clinical problems, mandatory reporting laws are valuable. What may be needed are revisions in the laws, a better and more uniform definition of what is reportable as suspected sexual abuse, uniform criteria to guide human services professionals in dealing with parents, and the establishment of minimal child welfare standards and decision-making guidelines. (A five-page bibliography is included. Tables list 20 reasons why human services professionals may avoid reporting sexual abuse and provide some guidelines for decision-making when reporting child sexual abuse.) (NB)

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Reporting Child Sexual Abuse:

Ethical Dilemmas, and Guidelines for Decision Making

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Reporting Child Sexual Abuse:

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Reporting Child Sexual Abuse: Ethical Dilemmas
and Guidelines for Decision-Making

Every state has a law which mandates that individuals or professional groups report suspected occurrences of child abuse. While the duty to report is aimed at benefiting the children, the mandatory reporting statutes, their administration, and their judicial interpretation have created many ethical, legal and clinical dilemmas (Saulsbury & Campbell, 1985; Guyer, 1982; Shectman, et.al., 1982; Sussman, 1974).

The child abuse and neglect statutes illustrate the legal contest between the rights of parents and the rights of the child. This legislation clearly establishes the state's prerogative to intervene and regulate intrafamily interactions. As a result, the mental health practitioner has been directly "recruited", through the enactment of mandatory reporting laws, into the service of the state and its designated administrative and judicial agencies (Guyer, 1982). These statutes intrude upon the privacy and confidentiality that has traditionally existed between patient and therapist. By interfering in the privileged or confidential nature of communications that take place in therapy, the mandatory reporting acts weaken the foundations upon which the therapeutic relationship is built (Sussman, 1974; Fleming & Maximov, 1974; Guyer, 1982).

The abrogation of confidentiality creates a clinical crisis and can throw the therapist in the midst of a dilemma. If a report is made, the therapist may become a witness against his/her client (in the case of an adult admitting to abuse). In the case of a child reporting

abuse, the therapist may worsen the situation for the child by reporting, since the child could be removed from the home and placed in inadequate foster conditions that are equally detrimental to health and well being. In either case, the therapeutic alliance may be destroyed. Alternatively, the failure to report places the therapist in direct opposition to the letter of the law and leaves him or her open to the threat of civil liability (Guyer, 1982; Hartley, 1981; Fischler, 1984; Goldstein, Freud & Solnit, 1973).

The abrogation of the confidentiality in the therapeutic relationship is probably the foremost ethical dilemma created by the mandated reporting statutes. However, there are other ethical and clinical problems that arise during the process of deciding whether or not to report. Additionally, there may be specific problems involved when reporting instances of sexual molestation. A review of the literature concerning the reporting decision process of human service professionals indicates that there are at least sixteen different factors or attitudes which can cloud or impede professional judgement. These factors are listed in Table 1.

One surprising trend in the earlier literature indicated that there was an inverse relationship between willingness to consider the diagnosis of suspected child sexual molestation and the individual's level of training. That is, the more advanced the training of some, the less willing they were to suspect molestation (Sgroi, 1975; Nagi, 1977). More recent studies suggest that there has been a sizeable increase in

the reporting of physical abuse and sexual abuse among doctors and other highly trained professionals (Serrano, 1983; Fischler, 1984; Saulsbury & Campbell, 1985), but fewer diagnoses are made of neglected children. (Saulsbury & Campbell, 1985). This phenomenon might be explained by the heightened media coverage during the past few years of physical and sexual abuse in comparison to the moderate coverage of neglect cases. Or it might be explained by the vague statutory and clinical definitions associated with neglect.

Reports of physical or sexual abuse which lead to judicial proceedings are less frequent today than in the past, but the potential social injury to the family is still enormous. In actuality, there are few studies which compare the number of reports made with the number of cases of actual physical or sexual abuse in a given jurisdiction (Sussman, 1974; Adams-Tucker, 1984). Additionally, there is no documented causal connection between mandatory reporting and a decrease in the amount of child abuse itself (Sussman, 1974; Finkelhor, 1979; Fischler, 1974). Reasons why human service professionals may avoid reporting sexual abuse are summarized in Table 1 below.

Goldstein, Freud & Solnit (1979) note that the limitations of the reporting laws often go unacknowledged in discussions about the best interests of the child. There is an expectation that the law and its agents have a magical power to do what is far beyond its means. The law in fact, is a relatively crude instrument which does not have the power to compel the development of human relationships and may indeed be able to destroy them. The crucial problem is how and to what extent the law

can, through the manipulation of a child's external environment, protect that child's physical growth and emotional well-being. Once reported, the investigative procedures, the social stigmas associated with sexual abuse, and inadequate treatment resources impede the legal system's efforts to intervene and effectively assist (Sussman, 1974; Fontana, 1984).

These problems illustrate some of the dilemmas that are created by the mandatory reporting laws. Some guidelines for decision-making for the human service professional when addressing the matter of sexual and child abuse are summarized in Table 2 below.

In summary, it should be noted that the authors favor mandatory reporting laws and their intention, in spite of the resulting ethical and clinical problems. Many authors have already advocated for revisions within the statutes themselves, including better and more uniform definition of what is reportable as suspected sexual abuse (Sussman, 1974; Sgroia, 1975; Fontana, 1984; Guyer, 1982). Uniform yardsticks and criteria need to be established to guide the human service professional toward more efficient collecting of information and dealing with parents. Minimal child welfare standards, and decision-making guidelines, based upon the best knowledge available and focused on the best interests of the child should be established (Pelton, 1978; McGowan & Meezan, 1983), and a model has been proposed here. These standards and guidelines would provide the human service professional with a solid reference base for decision making and action when confronted with a situation of suspected sexual abuse.

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Table 1

Reasons Why Human Service Professionals May Avoid Reporting Sexual Abuse

	Reason/Attitude	References
1.	Definitions of sexual abuse unclear. Statutes are vague and vary from state to state.	Sussman, 1974; Fischler, 1984; Finkelhor, 1979; McGowan & Meezen, 1983; Herbruck, 1979; Zuckerman, 1983, Westman, 1979; Adams & Roddey, 1981.
2.	Lack of training on the part of the professional; lack of knowledge about the laws.	Nagi, 1977; Saulsbury & Campbell, 1985; Helfer, 1975; Muehleman & Kimmon, 1981.
3.	Conflict of interests; parent rights versus child rights.	Nagi, 1977; Goldstein, Freud & Solnit, 1973; McGowan & Meezen, 1983; Muehleman & Kimmon, 1981; Guyer, 1982; Serrano & Gunzburger, 1983.
4.	Desire to maintain confidentiality (despite immunity statutes). Therapeutic alliance is destroyed.	Sussman, 1974; Berstein, 1984 Westman, 1979; Zingaro, 1983; Fleming & Maximov, 1974; Guyer, 1982; Muehleman & Kimmon, 1981.
5.	Basic philosophic disagreement with the law; desire for therapeutic versus penal interventions for offenders.	Sussman, 1974; Frude, 1982; Fischler, Comerci, Yates & Dover, 1983; Nagi, 1977; Goldstein, Freud & Solnit, 1973; Pelton 1978; Muehlemen & Kimmon, 1981; Fesbach & Fesbach, 1978; McGowan & Meezan, 1983.
6.	Inability to safeguard against false reports.	Sussman, 1974.
7.	Treatment outcomes for child and family are often worse after report is made.	Sussman, 1974; Berstein, 1984; Davis, 1983; Adams-Tucker, 1984; Hartley, 1981; Frude, 1982; Fischler, 1984; Pelton, 1978; Rabb, 1982; Guyer, 1982; Advisory Committee on Child Development, National Research Counsel, 1976.

(Table 1 - Cont.)

8.	Pressure of one's own peer group not to report.	Sgroi, 1975.
9.	Inadequate understanding about the problem; sexual aberration versus a problem of power and control.	Sgroi, 1982
10.	Cultural taboos against open discussion of sex.	Walter, 1975.
11.	Theoretical biases: influence of Freud (attributed to Oedipal fantasies and "blaming the victim") and Kinsey (downplaying his findings in his initial surveys about sexual attitudes).	Finkelhor, 1979; Westman; 1979.
12.	Ethnic and socioeconomic biases. (People from better socioeconomic backgrounds are less likely to be reported).	Nagi, 1977; Finkelhor, 1979. Rabb, 1982; Zuckerman, 1983.
13.	Age of child. (underreporting decreases as the age of the child increases).	Nagi, 1977; Finkelhor, 1979.
14.	Professional can solve the problem better by themselves.	Saulsbury & Campbell, 1975; Nagi, 1977; Sgroi, 1975.
15.	Lack of interagency cooperation; inability of various disciplines to work together.	Nagi, 1977; Pelton, 1978; Helfer, 1975; Swoboda, Elwork, Sales & Levine, 1978.
16.	Fear of losing business.	Nagi, 1977; Helfer, 1975; Fischler, 1985.
17.	Draws on time, finances and staffing in private practices, hospitals and schools.	Nagi, 1977; Helfer, 1975
18.	Minimum person reward. Rewards hard to identify.	Helfer; 1975.
19.	Subjective factors such as personal values, biases and idiosyncratic assumption about "ideals" of family life.	McGowan & Meezan, 1983.
20.	Experience in reporting.	Rabb, 1982.

Table 2

Some Guidelines for Decision-making When Reporting Child Sexual Abuse

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I. Recognize the problem:

Know the state laws and agency policy.
Develop an operational criteria for the diagnosis of sexual abuse in your agency.
Train staff members and supervisers to identify potential indication of sexual abuse.
Develop criteria for the minimum standards of parenting.
Inform each client at the onset of treatment of reporting obligation.

II. If sexual abuse is suspected, gather information and structure it:

Decide if the child has been harmed or is at risk of harm in the near future.
Be aware of the specific cultural and socioeconomic factors that impinge on the family.
Discuss the matter with the child and if possible, the family.
Discuss the situation in supervision or with peers.
Be aware of your own countertransference and theoretical biases.

III. Decide action:
Consider the options.

1. Ignore the requirement of reporting sexual abuse in service of higher ethical imperatives and run the risk of civil liability.
2. Use the obligation to report to coerce the patient to stop abusive behavior.
3. Comply with the mandate and deal with the therapeutic consequences.

IV. Carry out action:
If you decide to report:

Inform the parent of the legal requirement to report abuse.
Be direct, honest and straight forward to the client.
Keep parents informed about what is happening.
Develop follow up mechanisms for reported case.

V. Assessment of decision and action;

Evaluate results by following up on the case.
Attempt to revise any agency procedures that impeded the decision making process or follow up.
Continue to be aware of personal biases, countertransference or values that may influence judgement and actions.